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IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1996

Dennis C. Vacco, et al.,
Petitioners

v.

Timothy E. Quill, M.D., et al.,
Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

State of Washington,
Petitioner

v.

Harold Glucksberg, et al.,
Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

**BRIEF OF THE PROJECT ON DEATH IN AMERICA,
OPEN SOCIETY INSTITUTE, AS AMICUS CURIAE,
FOR REVERSAL OF THE JUDGMENTS BELOW**

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---------------------------------------	----

OTHER AUTHORITIES

- Susan Block & Andrew Billings, *Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 36 *Psychosomatics* 445 (1995) 25 n.23
- Susan Block & Andrew Billings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 *Arch. Intern. Med.* 2039 (1994) 16 n.11
- Eduardo Bruera, *Issues of Symptom Control in Patients with Advanced Cancer*, Mar./Apr. 1993, *Am. J. Hospice & Palliative Care*, 13 23 n.22
- Nathan Cherny, et al., *The Treatment of Suffering When Patients Request Elective Death*, 10 *J. Palliative Care* 71 (1994) 25 n.23
- Harvey Max Chochinov, et al., *Desire for Death in the Terminally Ill*, 152 *Am. J. Psychiatry* 1185 (1995) 26
- C.S. Cleeland, et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 *N. Eng. J. Med.* 592 (1994) 15 n.9

- Alfred P. Connors, et al., *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients; The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 *JAMA* 1591 (1995) 17, 18, 24
- K.E. Covinsky, et al., *The Impact of Serious Illness on Patients' Families*, 272 *JAMA* 1839 (1994) 20 n.16
- Kathleen Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 *J. Pain & Symptom Mgmt.* 289 (1991) 17 n.12
- J. Francis, et al., *A Prospective Study of Delirium in Hospitalized Elderly*, 263 *JAMA* 1097 (1990) 23 n.21
- Jay Katz, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1994) 24
- William Knaus, et al., *Short-Term Mortality Predictions for Critically Ill Hospitalized Adults: Science and Ethics*, 254 *Science* 389 (1991) 28 n.24
- Joanne Lynn, *Caring at the End of Our Lives*, 334 *N. Eng. J. Med.* 201 (1996) 27 n.24
- Joanne Lynn, et al., *Accurate Prognostications of Death: Opportunities and Challenges for Clinicians*, 163 *Western J. Med.* 250 (1995) 27-28 n.24

- Kristin Luker, *ABORTION AND THE POLITICS OF MOTHERHOOD*, 88-95 (1984) 13
- M.B. Max, *Improving Outcomes of Analgesic Treatment: Is Education Enough*, 113 *Ann. Int. Med.* 885 (1990) 17 n.12
- Neil McDonald, *Suffering and Dying in Cancer Patients: Research Frontiers in Controlling Confusion, Cachexia and Dyspnea*, 163 *Western J. Med.* 278 (1995) 23 n.20
- Steven Miles, et al., *End-of-Life Treatment in Managed Care: The Potential and the Peril*, 163 *Western J. Med.* 302 (1995)..... 21
- George Thibaut, *The Use of Clinical Models for 'End of Life' Decisionmaking in Critically Ill ICU Patients*, Summary of Committee Views and Workshop Examining the Feasibility of an Institute of Medicine Study of Dying, Decisionmaking, and Appropriate Care, 13:pp.1-3 (1994)..... 28 n.24
- J.H. Von Rouenn, et al., *Physician Attitudes and Practice in Cancer Pain Management*, 119 *Ann. Int. Med.* 121 (1993) 17 n.12
- Michael Wines & Robert Pear, *Health Costs Pose Problems for Millions, A Study Finds*, *N.Y. Times*, Oct. 23, 1996, at A18, col. 1..... 22 n.18
- American Medical Ass'n Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 *JAMA* 474 (1996) 15 n.9, 16 n.10-11

- Cancer Pain Relief and Palliative Care*, World Health Organization (Report of a WHO Expert Committee), 1990 18 n.13, 19 n.15
- Dying Well in the Hospital: The Lessons of SUPPORT*, 25 Hastings Center Report, Special Supp. S1-S36 (1995) 18 n.14

QUESTION DISCUSSED BY AMICUS

Whether the invalidation by the courts below of state laws prohibiting physician-assisted suicide should be overruled on the ground that the issue is not yet ripe for constitutional adjudication.¹

¹ Each party has given its consent, in writing, to the filing of this brief amicus curiae. Letters indicating such consent have been filed with the Clerk of the Court.

INTEREST OF AMICUS CURIAE

The Project on Death in America was established in 1994 by the Open Society Institute, a private non-profit operating foundation. Its mission is to understand and transform the culture and experience of dying in the United States through initiatives in research, scholarship, the humanities and the arts, and to foster innovations in the provision of care, public education, professional education, and public policy. This mission arose from a recognition, first, that the experience of dying has changed over the past several decades, with many more people enduring prolonged dying as a consequence of chronic and progressive disease and, second, that needless suffering -- physical, emotional, existential and spiritual -- too often accompanies these deaths, for both dying persons and survivors.

The Project takes no position on the question whether legal institutions should ultimately recognize a right to physician-assisted suicide, whether by legislative action or by judicial constitutional interpretation. Among individuals who are supported by, affiliated with, or responsible for the direction of the Project, there is no uniform view about whether physician-assisted suicide should be endorsed by legislative action or constitutional adjudication.

Among the enterprises supported by the Project, many are dedicated to implementing palliative care programs in hospital and community settings to alleviate the needless suffering that currently afflicts dying people and their families. Other supported programs are engaged in designing ways to enhance the autonomous choice of dying people in such matters as what treatments are provided to them, whether they die in institutional or home settings, and whether adequate financial and other community resources are available to support the choices preferred by dying people and their families. By these means, as well as by supporting evaluative research and

programs for public and professional education, the Project is addressing many of the justifiable fears that are the current predicates for the support of physician-assisted suicide, and is working to establish an adequate practical basis for evaluating effective safeguards for any future implementation of the practice of physician-assisted suicide.

Our goal is to promote a fully informed and equitable societal resolution of the question whether physician-assisted suicide should be legitimated, if at all, by legislation or as a constitutional right.

SUMMARY OF ARGUMENT

Legally recognized physician-assisted suicide is not currently in practice in any jurisdiction in the United States. It has not yet been implemented even in the one state (Oregon) where physician-assisted suicide was legalized by a popular referendum just two years ago. If this Court were to affirm the judgments below declaring a constitutional right to physician-assisted suicide, an abrupt, radical and utterly unprepared transformation of medical practice would be imposed on the entire country.

In *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), which considered a constitutional claim to refuse life-prolonging medical treatment for a mentally incompetent person, this Court proceeded with considerable caution and refused to enunciate a uniform constitutional rule, deferring instead to the "divers[e] . . . number of sources" available to states in considering such a "perplexing question with unusually strong moral and ethical overtones." *Id.* at 277. This Court thus followed Justice Brandeis' classic injunction to avoid premature constitutional decisions that close off state "experimentation" regarding "changing social . . . needs." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 310 (1932) (dissenting opinion).

Following this judicious course does not necessarily foreclose some future constitutional determination regarding an individual right to physician-assisted suicide by this Court. In many other contexts -- such as constitutional interpretations of due process rights in criminal trials, and rights against cruel and unusual punishment -- this Court has purposefully and explicitly stayed its hand so that states might explore different solutions to novel, complex social problems. In these contexts, the Court has made clear that extensive prior deliberation and experimentation in Brandeis' "laboratory" of the states is a necessary prerequisite for an adequately informed, ultimate judicial decision to enunciate a uniform, binding constitutional resolution.

This necessary prerequisite of extensive state deliberation and experimentation has hardly even begun regarding legally recognized physician-assisted suicide. In particular, there are serious unanswered questions about the capacity of physicians or state officials to ensure that a gravely ill individual's choice for physician assistance in suicide is adequately voluntary, or that the individual is mentally competent or is appropriately diagnosed as terminally ill. In the instant cases, however, the Courts of Appeals held that any constitutional right to physician-assisted suicide must be limited to voluntary, mentally competent, terminally ill individuals. The courts below ignored the multiple uncertainties currently involved in applying these criteria in individual cases. Because it is not yet certain that adequate criteria can be developed or applied, it is premature for any court to determine whether there is a federal constitutional right to physician-assisted suicide. The question is not ripe for constitutional adjudication and will not become ripe for an indeterminate time while various states, free from judicially-imposed constitutional compulsion, consider whether or on what terms physician-assisted suicide should be authorized. The judgments below should accordingly be reversed.

ARGUMENT

I. COURTS SHOULD NOT PRE-EMPT PUBLIC DEBATE AND LEGISLATIVE ACTION BY PREMATURE CONSTITUTIONAL RESOLUTION OF ISSUES WITH SUCH COMPLEX DIMENSIONS AS PHYSICIAN-ASSISTED SUICIDE.

A. Justice Brandeis' Approach: For "Novel Social Experiments," Courts Should Withhold Constitutional Resolution While Individual States, Serving As "Laboratories," Develop Adequate Practical and Research Experience.

The instant case is strikingly similar to *New State Ice Co. v. Liebmann*, 285 U.S. 262 (1932). In the heyday of its invocations of substantive due process to overturn state social and economic regulations, the Court held that a state law requiring a license to manufacture, sell or distribute ice was unconstitutional on the ground that this activity was "essentially private in nature" and that "under [the fourteenth] amendment, nothing is more clearly settled than that it is beyond the power of a state, 'under the guise of protecting the public, arbitrarily [to] interfere with private business . . .'" *Id.* at 277-78. Justice Brandeis dissented from this sweeping application of the "privacy" norm, in an opinion which the modern Court has acknowledged as "classic." *Whalen v. Roe*, 429 U.S. 589, 597 n. 20 (1977).

Justice Brandeis' reasoning applies with equal force to the invocations of constitutional norms of "privacy" or "arbitrariness" to overturn state laws against physician-assisted suicide, as in the Ninth and Second Circuit rulings in the instant case. Justice Brandeis' dissent makes this application clear:

To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation. It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country. This Court has the power to prevent an experiment. We may strike down the statute which embodies it on the ground that, in our opinion, the measure is arbitrary, capricious, or unreasonable. . . . But, in the exercise of this high power, we must be ever on our guard, lest we erect our prejudices into legal principles. If we would guide by the light of reason, we must let our minds be bold.

285 U.S. at 311.

In *New State Ice Co.* the Court prevented experimentation on a complex question of social and economic policy by striking down the novel state law. But that is not the only way that constitutional adjudication can override what Justice Brandeis referred to as the "value of the process of trial and error" in social experimentation. *Id.* at 310. A court can also prevent experimentation by prematurely imposing a constitutional resolution for the entire country regarding a novel and difficult issue at a time when individual states are engaged in testing the unknown or inadequately understood dimensions of this issue.

Assessing the merits and demerits of physician-assisted suicide is, in Justice Brandeis' words, "a formidable task" involving a "multitude of judgments." *Id.* (For a specification of many of the empirical uncertainties regarding this practice, see Part II, *infra*). Thus far only one state has directly embarked on this task by resolving to effectuate the practice; implementation of this experiment by the state of Oregon has been blocked by a federal district court's constitutional ruling.

Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995) (this ruling was explicitly disapproved in the Ninth Circuit opinion under review here, 79 F.3d at 839 & nn. 138-39). But this impediment should be removed and we would then have the benefit of what Justice Brandeis called "one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co.*, 285 U.S. at 311.

B. Regarding Physician-Patient Relations, the Modern Court Has Applied Justice Brandeis' Approach to Avoid Premature Constitutional Resolution of Novel, Factually Complex Issues.

The decision of this Court most directly relevant to the instant case is *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). *Cruzan* was "the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a 'right to die.'" *Id.* at 277. In *Cruzan*, the Court effectively endorsed Justice Brandeis' admonition to withhold constitutional resolution in order to promote the development of diverse state approaches. The Court favorably acknowledged the "diversity" of state common-law approaches to the "perplexing question with unusually strong moral and ethical overtones" of withholding life-prolonging medical treatment from incompetent patients. *Id.* The Court observed that a constitutional resolution of this question would wrongfully truncate the range of relevant considerations because of the "simpl[e] and stark" way that the issue would be posed in constitutional adjudication, whereas individual states have a "number of sources" available to them "which are not available to us" in federal constitutional adjudication. *Id.*

Cruzan explicitly acknowledged that the state regulation in that case directly impinged on the exercise of a

constitutionally protected "liberty interest." *Id.* at 278. The Court nevertheless recognized the propriety of diverse state approaches to the issue in light of its complex factual context.²

Justice O'Connor made clear in her concurring opinion in *Cruzan* that the Court's deference to diverse state approaches did not mean that no authoritative constitutional resolution would ever be judicially imposed,³ but only that such a resolution would be premature in light of the novelty and factual complexity of the issue.⁴

² The Court observed, "We follow the judicious counsel of our decision in *Twin City Bank v. Nebeker*, 167 U.S. 196 (1897), where we said that in deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.'" 497 U.S. at 277.

³ Justice O'Connor stated:

Today's decision, holding only that the Constitution permits a State to require clear and convincing evidence of Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn, does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment. As is evident from the Court's survey of state court decisions . . . no national consensus has yet emerged on the best solution for this difficult and sensitive problem. Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States, *New State Ice Co. v. Liebmann* . . . (Brandeis, J., dissenting), in the first instance. (497 U.S. at 292).

⁴ In another case that also directly impinged on constitutional rights in physician-patient relations, this Court was equally unwilling to impose a "simpl[e] and stark" constitutional rule. In *Whalen v. Roe*, 429 U.S. 589 (1977), the state had required physicians to report the names and addresses of patients for whom they prescribed certain medications and a lower court ruled that this requirement invaded "one of the zones of privacy accorded

(Continued)

C. The Modern Court Has Applied Justice Brandeis' Approach to Promote State Experimentation and Avoid Premature Constitutional Resolution in Many Other Contexts.

In a series of decisions addressing different constitutional provisions, the Court has purposefully withheld constitutional resolution in order both to permit and to promote experimentation by states. The underlying premise of these decisions has been that the experience and knowledge gained in these diverse state efforts would serve to clarify and refine the constitutional issues before any final judgment by this Court.

1. Interpreting the Fourteenth Amendment due process right to a fair trial.

Chandler v. Florida, 449 U.S. 560 (1981), was a constitutional challenge to the state's newly-instituted practice of broadcasting the proceedings of a criminal trial notwithstanding a defendant's objection. The Court ruled that on the facts of the specific case before it, no constitutional violation had been demonstrated. *Id.* at 574. The Court refused, however, to enunciate a general constitutional rule binding for future cases. "It is clear that the general issue of the psychological impact of broadcast coverage upon the participants in a trial, and particularly upon the defendant, is still a subject of sharp debate. . . . Comprehensive empirical data are still not available -- at least on some aspects of the problem." *Id.* at 577. The Court acknowledged that the state's

constitutional protection" in the doctor-patient relationship. The Supreme Court acknowledged that the state regulation had "some effect on individual liberty or privacy" but nonetheless concluded that "individual States [must] have broad latitude in experimenting with possible solutions to problems of vital local concern." *Id.* at 597.

action might "have an adverse effect" on the "detached atmosphere" necessary to protect a defendant's right to a fair trial. *Id.* at 578. Nonetheless, the Court found that "at present no one has been able to present empirical data sufficient to establish" this proposition, that "further developments and more data are required before this [constitutional] issue can be finally resolved." *Id.* at 578-80 & n. 12.

Notwithstanding the possibility that the continuation of the state policy would infringe on the fair trial right, the Court in *Chandler* clearly ruled that it was premature to resolve the constitutional issues until more experience had accumulated and more empirical data was available for adequate evaluation of the claims presented. The Court observed, "[T]he very broadcast of some trials potentially [may be] a form of punishment in itself -- a punishment before guilt. This concern is far from trivial. But, whether coverage of a few trials will, in practice, be the equivalent of . . . the public pillory long abandoned as a barbaric perversion of decent justice . . . must also await the continuing experimentation." *Id.* at 580-81. Citing "the admonition of Justice Brandeis, dissenting in *New State Ice Co.*," the Court concluded, "This concept of federalism . . . favoring Florida's experiment, must guide our decision." *Id.* at 580.

2. Interpreting the Eighth Amendment right against cruel and unusual punishments.

In several instances the Court has held that it would be premature to impose a uniform constitutional rule in the administration of capital punishment until more state legislatures had acted, more experience had accumulated and more empirical data was available for adequate evaluation of the claims presented. In *Penry v. Lynaugh*, 492 U.S. 302 (1989), the Court considered a constitutional claim that execution of mentally retarded people violated the Eighth Amendment ban against "cruel and unusual punishment." The

Court refused to endorse this constitutional claim but, at the same time, explicitly refused to rule out the possibility that future actions by state legislatures might someday justify the Court's proclamation of such a right.⁵

In a case decided just one year earlier, Justice O'Connor was equally explicit that constitutional judgment should be withheld until state legislatures had independently deliberated on the matter. In *Thompson v. Oklahoma*, 487 U.S. 815 (1988), the Court divided four-to-four on the question whether the Constitution forbade execution of a person under 16 years of age. In her separate opinion which constituted the rule of the case, Justice O'Connor refused to resolve the constitutional question and instead held only that no such juvenile could be executed without explicit statutory prescription by the state legislature. *Id.* at 855. Justice O'Connor concluded that more "careful consideration" on this issue should take place among state legislatures. *Id.*⁶

⁵ The Court stated:

Only one state [Georgia] . . . currently bans execution of retarded persons. . . . Maryland has enacted a similar statute which will take effect [imminently]. . . . [The petitioner] points to several public opinion surveys that indicate strong public opposition to execution of the retarded. . . . The public sentiment expressed in these and other polls and resolutions may ultimately find expression in legislation, which is an objective indicator of contemporary values upon which we can rely. But at present, there is insufficient evidence of a national consensus . . . for us to conclude that it is categorically prohibited by the Eighth Amendment. (492 U.S. at 334-35).

⁶ Justice O'Connor wrote:

The day may come when we must decide whether a legislature may deliberately and unequivocally resolve upon a policy authorizing capital punishment for crimes committed at the age of 15. . . . In my view, however, we need not and should not decide the question today.

...

(Continued)

The Eighth Amendment may appear especially hospitable to such deference to evolving legislative attitudes and experience since it forbids not simply "cruel" but also "unusual" punishments, and the Court has held that legislative actions might themselves be a measure of "unusualness."⁷ Nonetheless there is a more fundamental parallel between the jurisprudence of the Eighth and Fourteenth Amendments which establishes the equal relevance of state legislative actions for judicial interpretations of other constitutional provisions.

3. Interpreting Fourteenth Amendment "privacy" or "liberty" interests.

In *Trop v. Dulles*, 356 U.S. 86, 100-01 (1958), the Court stated "that the words of the [Eighth] Amendment are not precise, and that their scope is not static. The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society." This evolutionary conception is precisely the interpretive guide that Justice Harlan identified in his now-classic concurring opinion in *Griswold v. Connecticut*, 381 U.S. 479, 499 (1965), incorporating by reference his dissenting opinion in *Poe v.*

By leaving open for now the broader Eighth Amendment question . . . , the approach I take allows the ultimate moral issue at stake in the constitutional question to be addressed in the first instances by those best suited to do so, the people's elected representatives. (*Id.* at 855, 858-59).

⁷ Amicus Curiae believes that in the specific substantive contexts of these cases, the Court erred in refusing to prohibit on constitutional grounds the execution of mentally retarded persons or of minors under sixteen. Amicus relies on these cases only for the jurisprudential proposition that the Court may decline to declare a constitutional right while explicitly holding open the possibility of a future judicial declaration based on further state legislative developments.

Ullman, 367 U.S. 497, 522 (1961) ("Due process has not been reduced to any formula [I]t has represented the balance which our Nation, built upon postulates of respect for the individual, has struck between that liberty and the demands of organized society . . . having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke. That tradition is a living thing." 367 U.S. at 542).

In interpreting the Fourteenth Amendment due process guarantee in *Griswold*, it is clear that Justice Harlan gave the same weight to the accumulated actions and experience of state legislatures generally as the Court gave in its interpretations of the Eighth Amendment in *Penry* and *Thompson*. Justice Harlan stated, "[C]onclusive, in my view, is the utter novelty of this enactment. Although the Federal Government and many States have at one time or other had on their books statutes forbidding or regulating the distribution of contraceptives, none . . . has made the use of contraceptives a crime." *Poe v. Ullman*, 367 U.S. at 554 (emphasis in original).

In evaluating the Fourteenth Amendment due process claim advanced in the instant case, the absence of any state legislative endorsement except for the "utter novelty" of the Oregon statute leads to the conclusion that a constitutional right to physician-assisted suicide is not yet supported by a sufficient "national consensus" (*Penry*) or by "evolving standards of decency" (*Trop*) or by "the balance which our Nation . . . has struck between . . . liberty and the demands of organized society" (*Griswold*). The Courts of Appeals' decisions in this case turn Justice Harlan's reasoning upside down: instead of relying on the collective judgments of forty-nine states to support the imposition of a constitutional rule on one, these decisions effectively impose one lone state's judgment on the other forty-nine.

It is also relevant that when this Court invalidated state laws restricting abortion in *Roe v. Wade*, 410 U.S. 113 (1973), abortions were legally available in every state in some circumstances: to save the mother's life in all states, to safeguard the mother's physical or mental health in "about one third of the states" and simply on demand in four states. See *id.* at 139-40 & n. 37. (Indeed, the statutory criteria regarding the mother's physical or mental health were so liberally construed in some states as to virtually amount to a regime of abortion on demand. See Kristin Luker, *ABORTION AND THE POLITICS OF MOTHERHOOD*, 88-95 (1984).) State legislative endorsement of abortion was thus not an "utter novelty" as it currently is for physician-assisted suicide.

II. CONSTITUTIONAL RESOLUTION IS PREMATURE BECAUSE SUBSTANTIAL UNCERTAINTIES EXIST REGARDING THE POSSIBILITY OF DESIGNING EFFECTIVE SAFEGUARDS FOR THE PRACTICE OF PHYSICIAN-ASSISTED SUICIDE.

Both the Second and Ninth Circuit Courts of Appeals insisted that the constitutional right to physician-assisted suicide must only apply to individuals who voluntarily request it, who are mentally competent and who are terminally ill. See *Compassion in Dying v. Washington*, 79 F.3d at 793; *Quill v. Vacco*, 80 F.3d 716, 718 (2d Cir.), *cert. granted*, 135 L. Ed. 2d. 1127 (1996). Both courts acknowledged that states have a legitimate interest in prescribing safeguards to ensure that the practice is strictly limited to volunteering, mentally competent, terminally ill people. See 79 F.3d at 832-33; 80 F.3d at 730-31 & n. 4. Both courts assumed that sufficient empirical knowledge and professional experience were currently available on which states might rely in designing such safeguards. 79 F.3d at 826, 831, 833; 80 F.3d at 730-31.

These assumptions about the current preparedness of the states and the medical profession to design effective safeguards are false. For patients who might request physician-assisted suicide, there are considerable practical problems in assuring voluntariness, in both diagnosing and appropriately treating mental incompetence, and in determining terminal prognoses. These problems might be overcome in the future if empirical research is conducted and, in particular, if the new Oregon statute comes into effect and is carefully monitored, and if currently untested changes in medical education and institutional practices are implemented to prepare physicians for this novel, legally-recognized role. But there is no sufficient current basis in practical experience or rigorous empirical research for any confidence that adequate safeguards can be developed. The courts below have no basis for their assumptions that physician-assisted suicide can in practice be appropriately restricted to voluntary, mentally competent, terminally ill people. It is thus clearly premature for the judiciary to declare the existence of a constitutional right to physician-assisted suicide on the premise that this right must extend only to voluntary, mentally competent, terminally ill people.⁸

⁸ Similar difficulties may exist in assuring the voluntariness and mental competence of gravely ill individuals who refuse life-prolonging treatment. But the possible existence of such similarities provides no reason for extending a constitutional right from this narrower context of an individual's liberty interest in resisting unconsented bodily intrusions; the possible similarities provide strong reasons for caution rather than expansive adjudication. This Court, moreover, was appropriately cautious in its consideration of constitutional claims to refuse treatment in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), acting only after this right had been recognized during the preceding fifteen years by some fourteen state appellate court decisions. *Id.* at 277 n. 6. By contrast, only one state supreme court has just recently addressed the question of physician-assisted suicide presented in this case, *People v. Kevorkian*, 447 (Continued)

A. Voluntariness

1. **A dying person suffering from intense pain cannot voluntarily choose suicide unless available, effective pain treatment is offered.**

The most powerful and poignant argument on behalf of legalizing physician-assisted suicide is to provide release for terminally ill people from intense, intractable pain. For anyone forced to choose between continued life with such pain and the release of death, the pain obviously exerts an enormous and even overwhelming coercive impact. This impact in itself obviously cannot justify characterizing a choice for death as "involuntary." If, however, this pain is actually avoidable but the suffering individual is neither informed of this fact nor given the opportunity to alleviate this terrible pain, then this individual is not acting voluntarily in choosing death as the only or even the preferred way to end suffering.

Many dying people in this country today are suffering from insufficiently treated pain.⁹ Medically effective

Mich. 436, 527 N.W.2d 714 (1994), *cert. denied sub nom., Hobbins v. Kelley*, 115 S.Ct. 1795 (1995), and refused to find a constitutional right in the context of Jack Kevorkian's ministrations in that state.

⁹ How commonly pain marks the actual experience of dying is uncertain, and estimates vary substantially across institutions, whether hospices or hospitals. Coyle et al. reported that three of every four cancer patients had pain. Bonica's review of published reports indicates that more than half of cancer patients have severe pain. Saunders has claimed that one fourth of cancer patients have inadequate pain control when dying.

American Medical Ass'n Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996) (citations omitted) (*hereinafter, Good Care of the Dying Patient*). See also C.S. Cleeland, et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 N. Eng. J. Med. 592 (1994).

techniques for completely alleviating this pain are available for almost all of these people; according to knowledgeable physicians and researchers, this is possible in as many as ninety-eight percent of cancer cases.¹⁰ But the medical profession generally is neither informing patients of this possibility nor providing this palliative care.¹¹

We do not adequately understand the reasons for this failure by the medical profession; nor do we understand how this medical failure can be effectively remedied. There are many possible explanations, such as: insufficient knowledge among physicians about pain management because of inadequate professional training; state and federal legal restrictions on availability of controlled substances for pain

¹⁰ [O]nly 2% of patients in hospice care experience pain that is difficult for a skilled team to manage. With the exception of one study, other investigators confirm this low rate of serious pain persisting in systems of care that emphasize pain management. The rates of pain in persons who are dying of diseases other than cancer are not [however] well described.

Good Care of the Dying Patient, 275 JAMA at 475 (citations omitted).

¹¹ The potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts. . . . Although guidelines and a curriculum on pain management have been developed, oncologists and others report serious perceived shortcomings in management of cancer pain.

Good Care of the Dying Patient, 275 JAMA at 475. Other distressing symptoms of dying patients, in addition to pain, are also inadequately treated by physicians. See Susan Block & Andrew Billings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 Arch. Intern. Med. 2039, 2040 (1994) ("Other symptoms [beyond pain] (eg., dyspnea, anorexia, nausea, constipation, insomnia, and anxiety) regularly plague terminally ill patients and are often inadequately controlled by physicians who lack expertise in palliative care or fail to take an aggressive stance toward assuring patient comfort.").

relief and/or physician misconceptions about the legal restrictions; failure even to acknowledge a patient's pain because of unwillingness or inability of physicians and other medical personnel to engage in more than perfunctory conversation, or in many cases any conversation, with patients who are perceived as dying.¹²

The explanation for this failure cannot plausibly be cruelty or callousness of the medical profession; there is widespread acknowledgment and dismay within the profession about our failure to provide even minimally adequate pain palliation for most dying people. But we do not know enough about the causes of this failure to prescribe confidently effective remedies for it.

The most recent and disturbing indication of our ignorance is the research results of the so-called SUPPORT project. This four year study involving nine thousand seriously ill adult patients in five U.S. teaching hospitals was designed "to improve end-of-life decision making and reduce the frequency of a mechanically supported, painful, and prolonged process of dying." Alfred P. Connors, et al., *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients; The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments* (SUPPORT), 274 JAMA 1591 (1995). Phase I of the study, to establish the empirical baseline of practices current in 1989-91, documented that overall "50% of all conscious . . . patients who died in the hospital experienced moderate or severe pain at least half the time

¹² See Kathleen Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symptom Mgmt. 289, 290-93 (1991); M.B. Max, *Improving Outcomes of Analgesic Treatment: Is Education Enough?* 113 Ann. Int. Med. 885 (1990); J.H. Von Rouenn, et al., *Physician Attitudes and Practice in Cancer Pain Management*, 119 Ann. Int. Med. 121 (1993).

during their last 3 days of life" although there was "substantial variation" among the five hospitals. *Id.* at 1594.¹³ In Phase II, conducted in 1992-94, patients were divided into intervention and control groups, with the intervention group receiving intensive services from a "specially trained nurse" who, among other functions, facilitated communication and "encouraged attention to pain control" between the medical care team and patients and their families. 274 JAMA at 1591. Unfortunately, this "phase II intervention failed to improve care or patient outcomes." *Id.* In particular, reports of untreated pain during the last three days of life actually somewhat increased among intervention group patients as compared to control group patients. *Id.* at 1595.

The SUPPORT study was the most comprehensive research on the experience of dying patients ever conducted in this country. The failure of its intervention not simply to correct but even to measurably affect the problem of unnecessary but untreated pain among dying patients is a puzzling result.¹⁴ Amicus curiae, the Project on Death in

¹³ This base-line result was consistent with numerous other prior research reports. See *Cancer Pain Relief and Palliative Care*, 19, World Health Organization (Report of a WHO Expert Committee) (1990).

¹⁴ As the research observed:

The study certainly casts a pall over any claim that, if the health care system is given additional resources for collaborative decision making in the form of skilled professional time, improvements will occur. . . . [T]he overall results of this study are not encouraging. No pattern emerged that implied that the intervention was successful for some set of patients or physicians or that its impact increased over time. The five hospitals had been chosen for their diversity and their willingness to undertake a substantial and controversial challenge. Yet none showed a tendency toward improvement in these outcomes.

274 JAMA at 1596. See generally *Dying Well in the Hospital: The Lessons of SUPPORT*, 25 Hastings Center Report, Special Supp. S1-S36 (1995).

America of the Open Society Institute, is currently supporting the establishment of palliative treatment programs as well as research into the effectiveness of such programs in medical centers throughout the country. We hope that this work will soon demonstrate a considerable improvement of the current, intolerable regime of dying patients suffering unnecessary, treatable pain.

So long, however, as substantial numbers of dying people are unnecessarily suffering from treatable pain, no one can claim that an individual's choice to end his life rather than endure pain is a sufficiently voluntary act. States cannot design adequate safeguards to assure that every suffering person has access to available pain control treatment when we do not yet understand the reasons why such treatment is not being provided to large numbers of patients. Until state authorities, assisted by medical researchers, have understood these reasons and identified effective remedies, judicial pronouncement of a right to physician-assisted suicide, premised on the voluntary character of an individual's choice, would clearly be premature.

It is also possible that, in itself, recognition of a right to physician-assisted suicide would create barriers to the provision of effective pain control and other symptomatic relief to dying patients. This paradoxical result could arise because some pharmacologic measures that are medically necessary to relieve intense pain or other symptoms can also have the unintended effect of hastening death. Even though such measures violate neither legal nor ethical proscriptions, some physicians are currently reluctant to administer adequate palliative medications because of their potential life-shortening effect.¹⁵ If physician-assisted suicide were legalized and

¹⁵ See *Cancer Pain Relief and Palliative Care*, 52-53, World Health Organization (Report of a WHO Expert Committee) (1990).

accompanied by stringent procedural safeguards, many more physicians might conclude that even their current practices of pain control might require observance of these stringent new procedures. The net result could be the imposition of new barriers to the provision of currently recognized palliative care measures, thus increasing the already large numbers of patients who suffer needlessly from inadequate pain control. This paradoxical result would not inevitably follow from legalized physician-assisted suicide, but carefully designed implementation measures would be required to guard against this possibility. In common, however, with all of the current barriers to inadequate medical provision of palliative measures, we do not yet know enough about the underlying reasons for these barriers in order to design effective remedies to overcome them.

2. Undue financial pressures can undermine the voluntariness of a dying person's choice for suicide.

Prolonged dying from chronic illness, which is the increasingly common mode of death in this country, can be extremely expensive for patients and their families, as well as for private and public health insurers.¹⁶

Institutional arrangements in the delivery of health care are now in the midst of a fundamental transformation, as increasingly large numbers of patients are choosing, or are being forced by their employers or by state agencies to accept, the provision of medical treatment through managed care organizations. "The most troubling issue for end-of-life care in managed care is the possibility that clinicians are changed from being patients' advocates to having a personal stake in

¹⁶ See generally K.E. Covinsky et al., *The Impact of Serious Illness on Patients' Families*, 272 JAMA 1839 (1994).

withholding treatment that would be in the patients' interests." Steven Miles, et al., *End-of-Life Treatment in Managed Care: The Potential and the Peril*, 163 Western J. Med. 302, 304 (1995).¹⁷

Because the dominance of managed care organizations in American health care is relatively recent, there has been little systematic study of the extent of inappropriate cost-cutting pressures on patients. But if physician-assisted suicide suddenly becomes a constitutionally-sanctioned option for all patients, it is certainly plausible and perhaps even likely that budget-minded health care organization managers and their physician-employees would press their dying patients toward exercising this option.

Perhaps traditional patient-centered medical ethics would guard against this improper pressure; perhaps external regulation of the new health care organizations would adequately protect dying patients against undue influence. But our experience of managed care is too new for any confident claims on this score. And yet, as Judge Reinhardt's opinion for the Ninth Circuit explicitly recognized, without carefully designed safeguards to counteract "the risk of undue influence" for financial gain, a dying person's choice of physician-assisted suicide would not be a truly voluntary act. 79 F.3d at 826.

¹⁷ As Miles, et al. observe:

Health maintenance organizations (HMOs), preferred provider plans, and managed indemnity insurance cover 80% of the privately insured persons in the United States. Recent large-scale extensions of managed care to public programs of Medicare and Medicaid ensure the continued rapid growth of managed care. The *raison d'être* of managed care is to contain the growth of the cost of end-of-life care. About 10% of health care resources are used for the care of persons in their last year of life. (163 Western J. Med. at 302).

Unjustified financial pressures would be even more powerful for the large proportion of the American public without any health insurance, some thirty-seven million according to recent estimates.¹⁸ Once again Judge Reinhardt's opinion noted the problem ("We would be inclined to agree that the country's refusal to provide universal health care, and the concomitant suffering so many Americans are forced to undergo, demonstrates a serious flaw in our national values," 79 F.3d at 826), but nonetheless failed to acknowledge the central relevance of this problem to the constitutional legitimization of physician-assisted suicide. Unless there can be adequate assurances that no person chooses physician-assisted suicide because of poverty, this choice cannot be considered sufficiently voluntary. The judiciary is, however, neither institutionally capable nor constitutionally authorized to create a system to guarantee health care regardless of income.¹⁹ If there should be a right to physician-assisted suicide, it must be accompanied by general recognition of society's obligation to ensure access to adequate health care. The judiciary acting alone cannot achieve this goal.

¹⁸ See Michael Wines & Robert Pear, *Health Costs Pose Problems for Millions, A Study Finds*, N.Y. Times, Oct. 23, 1996, at A18, col. 1.

¹⁹ See, e.g., *San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. 1 (1973) (complex issues regarding equalization of school financing are not amenable to judicial resolution based on a constitutional claim for equal protection); *Dandridge v. Williams*, 397 U.S. 471 (1970) (state welfare law computations of family financial need are not amenable to judicial resolution based on equal protection claims).

B. Mental Competence

1. Judgment-impairing confusion is common among dying persons but is surprisingly difficult to identify as such.

"Confusional states are common" among dying people and, accordingly, "obtaining a truly informed consent is problematic."²⁰ It might seem self-evident that such confusional states would be readily detected by physicians or even by lay observers such as family members, and requests for assisted suicide would be appropriately disregarded. In actual practice, however, the detection of judgment-impairing confusion among dying people is surprisingly difficult.²¹ Based on several studies of dying patients, one researcher concluded that "our clinical observations miss profound confusional episodes in 20 percent of our patients."²²

²⁰ Neil MacDonald, *Suffering and Dying in Cancer Patients: Research Frontiers in Controlling Confusion, Cachexia, and Dyspnea*, 163 Western J. Med. 278, 280 (1995).

²¹ Physicians frequently fail to recognize cognitive impairment in hospitalized patients and may miss delirium because of its fluctuating features and subtle presentation. When physician diagnosis is required to identify cases of delirium, reported rates have been quite low. . . . Although physicians diagnosed delirium in only 8 patients, we found 50 patients (22% of the study population) who met criteria for the disorder . . . In this study of elderly patients on medical services, delirium occurred in over one fifth of subjects and was usually evident within 48 hours of admission. Our prospective surveillance identified many more patients with delirium than were seen by psychiatric consultants or diagnosed by physicians.

J. Francis, et al., *A Prospective Study of Delirium in Hospitalized Elderly*, 263 JAMA 1097, 1098, 1100 (1990).

²² Eduardo Bruera, *Issues of Symptom Control in Patients with Advanced Cancer*, Mar./Apr. 1993, Am. J. Hospice & Palliative Care, 13.

These results are consistent with more general observations in the SUPPORT study about shortcomings in communications between physicians and dying patients. The SUPPORT study found in Phase I that, of the patients who had expressed preferences for withholding cardiopulmonary resuscitation, "only 47% of their physicians accurately reported this preference." 274 JAMA at 1594. In Phase II, for the intervention group in which a specially trained nurse talked with both physicians and patients on a regular basis regarding patient preferences, among other things, the SUPPORT study found essentially no improvement in physicians' understanding of patients' preferences.

It thus appears that dying patients and their physicians are generally reluctant to talk with one another about matters of profound importance ("discussions and decisions substantially in advance of death were uncommon," 274 JAMA at 1595), and that there are substantial misperceptions between physicians and patients when conversations do occur. (These profound silences and miscommunications between physician and dying patients are often mirrored in general doctor-patient interactions. See generally Jay Katz, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).)

This pattern of persistently missed communications appears to confirm the finding that physicians and nurses regularly overstate dying patients' decision-making competence. Whatever the reasons, it is clear that state authorities and medical professional groups face a very difficult task, and currently have inadequate experience or research data, in order to design reliable safeguards to ensure the lucidity of dying patients who might claim a right to assisted suicide.

2. Judgment-impairing depression is common among dying persons and, not surprisingly, is difficult to identify as such.

Distinguishing between a dying person's profound sadness and an appropriate psychiatric diagnosis of clinical depression is exceedingly difficult.²³ For many reasons, however, drawing this distinction with accuracy and sensitivity is important in designing appropriate treatment for all dying people in order to provide the greatest possible satisfactions (for conversations, for reconciliations, for good leave-takings) for them and for their families. Identifying clinical depression is even more important when crucial decisions, such as refusing further medical treatment or requesting assisted suicide, are at stake; clinical depression, which commonly carries deep feelings of personal worthlessness and hopelessness, distorts an individual's rational capacity to make choices.

²³ [D]epression and organic mental disorders are commonly seen among patients who request assistance in dying. These disorders can both impair patient autonomy and coexist with autonomous wishes for hastened death. . . . Determination of competence in this setting is often extraordinarily challenging, requiring subtle evaluations of thought processes and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of alternative choices.

Susan Block & Andrew Billings, *Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 36 Psychosomatics 445, 451-2 (1995). See also Nathan Cherny, et al., *The Treatment of Suffering When Patients Request Elective Death*, 10 J. Palliative Care 71, 73 (1994) ("Undertreatment [of depression among terminally ill patients] derives largely from the problems of recognition and assessment and from the misconception that depression is a normal response to cancer.").

There has been little systematic research regarding the mental status of dying people who request assisted suicide or refuse life-prolonging treatment. The limited available investigations suggest two propositions: first, that among terminally ill patients "the desire for death could be quite variable over time"; and second, that clinical differentiation between a "psychologically stable" and a distorted decision is "in practice . . . a difficult distinction to make without actually initiating a course of treatment." Harvey Max Chochinov, et al., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1189-90 (1995).

Safeguards could be designed for the administration of physician-assisted suicide to take account of these considerations. It is not clear, however, that the procedures currently followed in the Netherlands -- the only country with any experience of this legally recognized practice -- do give adequate attention to the related issues of temporal instability and the difficulties of accurate psychiatric diagnosis. As Chochinov, et al. observe, "Although the Dutch guidelines are explicit with respect to the requirement that the request for an assisted death must be persistent over time, it has been reported that in practice, 65% of all euthanasia deaths occur within 2 weeks of the initial request" -- a time span which would be too brief to take account of the "temporal instability of the desire for death that was observed in our group" of patients. *Id.* at 1190.

The Ninth Circuit has specified that, consistent with its finding of a constitutional right to physician-assisted suicide, a state may adopt regulations requiring "reasonable, though short, waiting periods to prevent rash decisions." 79 F.3d at 833 (emphasis added). Would that court consider a two-week waiting period too short, just right, or too long to give adequate respect to a dying person's constitutional right to make a voluntary, mentally competent choice for physician-assisted suicide? There is today insufficient practical

experience and empirical research for rendering any confident judgment on the lapse of time necessary to assure that an individual's decision is not "rash" or clouded by depression or other psychiatric illness. This is yet another uncertainty that attends the administration of physician-assisted suicide, and yet another reason that it is premature for courts to take constitutional command of this issue.

C. Prognosis of Terminal Illness

Both of the courts below explicitly limited the constitutional right for assisted suicide to "terminally ill" people. Both courts were confident, moreover, that reliable identification of "terminally ill" people would not be especially difficult. The Second Circuit stated, "[I]t seems clear that most physicians would agree on the definition of 'terminally ill,' at least for the purpose of the relief that plaintiffs seek." 80 F.3d at 731. The Ninth Circuit stated that "the experience of the states has proved that the class of the terminally ill is neither indefinable nor undefined." 79 F.3d at 831.

Both courts are correct that physicians in various contexts are required to determine whether a patient has a "terminal illness." For example, for purposes of admission to hospice programs and eligibility for the Medicare hospice benefit, a patient must be diagnosed as likely to die within six months. There is, however, a substantial degree of uncertainty that attends this prognosis.²⁴

²⁴ See Joanne Lynn, *Caring at the End of Our Lives*, 334 N. Eng. J. Med. 201 (1996). Even though various objective scales for assessing terminal prognoses have been developed in recent years, in order to supplement the more subjective evaluations that individual physicians have always made, it is nevertheless true that all of these judgments remain uncertain. "[T]he pace of dying is affected by many factors over a substantial period of time. . . . Prognosticating will always be inescapably difficult." Joanne Lynn, et

(Continued)

Whatever the justifications for using "terminal illness" predictions in medical decisionmaking, there are special problems that arise when courts use statistical reasoning in determining whether an individual does or does not have a constitutional right. The use of "terminal illness" by the courts below serves to exclude people from exercise of what is held to be a constitutional right.

If a state legislature were to enact such a predictive criterion for excluding people from the exercise of a constitutional right, courts would not hesitate to overturn this restriction on grounds of overinclusive and underinclusive violations of strict scrutiny review. To predict accurately that 100 individuals have a 50% chance of dying within six months, for example, means that in the aggregate 50 of them will die and 50 will not, but it is impossible to determine whether a given individual will be among the living or the dead at the end of the six month period. Accordingly, it is overinclusive to award the constitutional right for choosing assisted suicide to the surviving half of these 100 people. At the same time, the predictive model cannot definitively establish that no one except these 100 individuals with similar

al., *Accurate Prognostications of Death: Opportunities and Challenges for Clinicians*, 163 *Western J. Med.* 250, 251 (1995). "[N]o matter how sophisticated they become, objective probability estimates represent substantial simplifications of very complex systems." William Knaus, et al., *Short-Term Mortality Predictions for Critically Ill Hospitalized Adults: Science and Ethics*, 254 *Science* 389, 393 (1991). "The [predictive] models produce probability estimates. They are developed and validated on large patient populations. . . . They have not been validated for individual patient decisions. . . . [W]e are far from achieving the goal of using individual patient level predictors to make difficult and painful decisions regarding . . . critically ill patients." George Thibaut, *The Use of Clinical Models for 'End of Life' Decisionmaking in Critically Ill ICU Patients*, Summary of Committee Views and Workshop Examining the Feasibility of an Institute of Medicine Study of Dying, Decisionmaking, and Appropriate Care, 13:pp.1-3 (1994).

prognostic characteristics will die of a given disease within six months. Accordingly, it is underinclusive to exclude from the constitutional entitlement people with statistically better prognoses who will in fact die during the six-month period.

If courts refrain from proclaiming a constitutional right in this matter, state legislatures could adopt laws restricting physician-assisted suicide to "terminally ill" people without transgressing the mandate of strict scrutiny. The new Oregon enactment does limit its authorization for assisted suicide to adults "suffering from a terminal disease," defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." OR. REV. STAT., tit. 13, ch. 127, §§ 2.01, 1.01(12). Courts have held that, in the absence of any infringement on constitutionally protected liberties, such restrictions are valid exercises of legislative authority. See *Williamson v. Lee Optical Co.*, 348 U.S. 483, 489 (1955).

This cautiously incremental methodology is readily available to legislatures but not to courts in constitutional adjudication. A court is not free to pronounce constitutional rights by selecting only "one phase of one field . . . [while] neglecting the others" any more than a legislature would be free to enact arbitrary limits on the availability of court-proclaimed constitutional rights. *Id.* Regarding physician-assisted suicide, moreover, this "one step" for terminally ill people has been taken thus far only by one state. As Justice Brandeis observed in *New State Ice Co.*, "it is one of the happy incidents of the federal system" that this one state can act "without risk to the rest of the country." 285 U.S. at 311.

The very fact that the courts below felt compelled to limit the reach of their proclaimed constitutional right to this inherently imprecise and individually indeterminable category of the "terminally ill" itself demonstrates their implicit understanding that reform in this sensitive and uncertain area

should proceed "one step at a time." The patent unsuitability of this category in constitutional adjudication itself demonstrates that the entire subject-matter of physician-assisted suicide is, at this early moment in public and legislative deliberations about it, not ripe for constitutional resolution.

CONCLUSION

There is no practical experience in any state with the administration of legally recognized physician-assisted suicide, even in the one state where it has only recently been legislatively approved. Although the courts below in the instant cases held that a constitutional right to physician-assisted suicide must be limited only to voluntary, mentally competent, terminally ill people, there are serious questions -- which cannot be answered based on currently available knowledge and experience -- about whether any of these limitations can be adequately determined in practice. Until additional practical experience and systematic research occurs regarding these questions -- in the "laboratories of the states" -- it would be premature to declare whether or not there is a federal constitutional right to physician-assisted suicide. Accordingly, the decisions of the courts below should be reversed on the ground that the issue presented was not ripe for constitutional adjudication.

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